

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-050616

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 241

FILED JAN 7 1964

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Cedar</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada, Mo</u>		c. CITY OR TOWN <u>Jessie Spry</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>James Nursing Home</u>		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b <u>1 yr</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>G RAYCE-SCOTT-THORNTON</u>			4. DATE OF DEATH Month Day Year <u>12-24-1963</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-1885</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>4 12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (City and state or country) <u>Decatur, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>		13a. FATHER'S NAME <u>James Scott</u>		13b. MOTHER'S MAIDEN NAME <u>Harrison</u>	
14. NAME OF HUSBAND OR WIFE <u>J. F. Thornton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>18</u>	
17. INFORMANT <u>J. F. Thornton, Jessie Spry, Mo</u>		18. ADDRESS		19. ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Arteriosclerosis</u>		<u>Unknown</u>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from August 19, 1963 to Dec. 24, 1963 and last saw her alive on Dec. 20, 1963  
Death occurred at Nevada, Missouri 5:30 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>L. P. McCann, M.D.</u>	22b. ADDRESS <u>Moore Building, Nevada, Mo.</u>	22c. DATE SIGNED <u>12/31/1963</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>12-24-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Our Cem</u>	23d. LOCATION (City, town, or county) (State) <u>5 S.E. Jessie Spry, Mo</u>
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24. FUNERAL DIRECTOR <u>Dr. D. Long, Jessie Spry, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-27-64</u>	26. REGISTRAR'S SIGNATURE <u>Anna G. Jemp</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *A. D. Long*

Licensed Embalmer No. 3714

P. O. Address *Green Bay, Wis.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.